Request for Reimbursement Form

Vendor Contact Name: Phone #: E-mail:

Vendor Stamp	City	County

ATTACH CHECK HERE

Attach Cash Register Receipt Here

Mail to:

KDHE – BFH – Nutrition and WIC Services
1000 SW Jackson, Suite 220
Topeka KS 66612-1274

Please describe the extenuating circumstance that led to the rejection of the check. Explain your plan of action for re-training employees to avoid a repeat of this error in the future.

*** STATE AGENCY USE***
Completed review of check. Findings are as follows:

- ☐ **Approved** Date _____ Initials: _____
- ☐ Reimbursement issued for full amount. $ _____
- ☐ Reimbursement issued for reduced amount. $ _____
- ☐ **Denied** Date _____ Initials: _____
- ☐ Sold over quantity of items listed on WIC check.
- ☐ Sold products not listed on WIC check.
- ☐ Missing client signature after deposit.
- ☐ Other:

State Agency Comments: _____